

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
14425													
14431													
1. PLACE OF DEATH a. COUNTY QUEEN ANNE MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SUDLERSVILLE						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rock Hall							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kitty's Nursing Home						d. STREET ADDRESS 142							
3. NAME OF DECEASED (Type or print) First FRANK Middle AYRES Last AYRES						4. DATE OF DEATH Month OCTOBER Day 25 Year 1967							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-14-1812		9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Dominick Ayres						14. MOTHER'S MAIDEN NAME CATHERINE CASEY							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-52-9013		17. INFORMANT T. BAYARD AYRES - Rock Hall Md. Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Hypertension DUE TO (c) Orbital Lobes												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Stroke												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stroke	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 7				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Jan , 1966 to Oct 25 , 1967, that (I) (we) last saw the deceased alive on Oct 19 , 1967, and that death occurred at 2 AM , from the causes and on the date stated above.													
22a. SIGNATURE C. H. Metcalfe						22b. DATE SIGNED 10/26/67							
22c. PHYSICIAN'S NAME (Type) C. H. Metcalfe						22d. ADDRESS SUDLERSVILLE MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF OCT. 28		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		23d. LOCATION (City, town or county) (State) Rock Hall MD.					
24. FUNERAL DIRECTOR Edgar D. Lane - Church Hill Md.						25a. REC'D BY REGISTRAR DATE OCT 31 1967		25b. REGISTRAR'S SIGNATURE J. Charles Jones					

QUEEN ANNE
ST. LOUIS
KITTY'S NURSING HOME

PARKLAND
KENT

FRANK
PALE WHITE
CARPENTER

APR 22
MARYLAND

250-2-1010
GREEN TROOP
CHURCH

CHURCH
C.H. MOTOR
SUBSIDIARY
CHURCH

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VR A15 (4)
20M 1/65

14426
14432
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Queen Anne's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pondtown, Rural Millington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pondtown, Rural Millington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First DAVID Middle GREER Last GREER		4. DATE OF DEATH Month October Day 6 Year 19 67	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July, 23, 1907
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Building Supplies	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Booker Greer		14. MOTHER'S MAIDEN NAME Daisey Purvis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes. W W.W.II		16. SOCIAL SECURITY NO. 148-09-9183	
17. INFORMANT Mrs. Rachel Greer,		Address Rural Millington, Md. 21651	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Rupture 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Vascular Disease DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Stroke		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 5 , 19 67 , to Oct 6 , 19 67 that (I) (we) last saw the deceased alive on Oct 5 , 19 67 , and that death occurred at 6:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE C. H. Metcalfe		22b. DATE SIGNED 10/7/67	
22c. PHYSICIAN'S NAME (Type) C.H. Metcalfe, M.D.		22d. ADDRESS Sudlersville, Md. 21668	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 9, 1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		23d. LOCATION (City, town or county) (State) Pondtown, Md.	
24. FUNERAL DIRECTOR Edward Fellows & Son,		ADDRESS Millington, Md. 21651	
25a. REC'D BY REGISTRAR OCT 10 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

1945

UNITED STATES OF AMERICA

1945

London, England

London, England

DAVID

July 1, 1945

London

My wife

William

London

My dear

My dear

London, England

London, England

London, England

London, England

London, England

London, England

London, England

London, England

London, England

London, England

London, England

London, England

London, England

London, England

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14433

FOR STATE
HEALTH DEPT.

14427

1. PLACE OF DEATH a. COUNTY QUEEN ANNE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CENTREVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CENTREVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) WILLIAM ROBERT HIGGS		4. DATE OF DEATH Month OCTOBER Day 19 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 24-1940
9. AGE (In years last birthday) 26 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) FARM OWNER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM J. HIGGS		14. MOTHER'S MAIDEN NAME DOROTHY MAY ECK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT WM. J. HIGGS - HENDERSON MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9121 IMMEDIATE CAUSE (a) Crashing injury to skull, occipital frontal region DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Instantaneous	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Engine gear under foot directly on skull & descend	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:30 AM - 10/17 1967	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home farm	20f. (City or town) Ingleside (County) Queen Anne's (State) MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John R. Smith M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Richard Smith, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF OCT. 22	23c. NAME OF CEMETERY OR CREMATORY SUDLERSVILLE	23d. LOCATION (City or Town) (County) (State) SUDLERSVILLE Q.A. MD.
24. FUNERAL DIRECTOR Edgar L. Lane - CHURCH HILL, MD.		25. REC'D BY REGISTRAR OCT 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 10-100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11/13/61

11/13/61

Went to ...
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Crashing injury to skull
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14428											
14434											
1. PLACE OF DEATH a. COUNTY QUEEN ANNE MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GRASONVILLE						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GRASONVILLE 17-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) XX						d. STREET ADDRESS XX					
3. NAME OF DECEASED (Type or print) First Middle Last MARGURITE MAE HORNEY						4. DATE OF DEATH Month Day Year OCTOBER 18 1967					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 5 - 1894		9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY XX		11. BIRTHPLACE (County & State, or foreign country) G.A. Co. MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE MILLER						14. MOTHER'S MAIDEN NAME MARY ROSE EVANS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. XX		17. INFORMANT RAYMOND HORNEY-GRASONVILLE Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Rheumatoid Arthritis											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNOERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4-1 , 19 67 to 10-18 , 19 67 , that (I) (we) last saw the deceased alive on 10-18 , 19 67 , and that death occurred at 12:20 M, from the causes and on the date stated above.											
22a. SIGNATURE Ralph E. Libby						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-20-67			
22c. PHYSICIAN'S NAME (Type) RALPH E. LIBBY						22d. ADDRESS GRASONVILLE MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF OCT. 21		23c. NAME OF CEMETERY OR CREMATORY CHESTERFIELD		23d. LOCATION (City, town or county) (State) CENTREVILLE MD.			
24. FUNERAL DIRECTOR Edgar L. Lane				ADDRESS CHURCH HILL MD.		25a. REC'D BY REGISTRAR OCT 24 1967		25b. REGISTRAR'S SIGNATURE John Charles Judge			

George Hunt
 Gersonville
 Life

MARGARITE X
 MAE HUNT
 AUG 2 - 1884 JS

HUSBAND
 GEORGE MILLER
 MARY ROSE LEWIS
 RAYMOND HORNBY - Gersonville

RUTH E. LEE
 BURIAL OCT 21 CHESTERFIELD Gersonville MD
 Church Hill Road 1887

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CERTIFICATE OF DEATH

14428

14435

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barclay</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barclay</u>			
c. LENGTH OF STAY IN 1b <u>Lifetime</u>				d. STREET ADDRESS <u>xx</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>xx</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bert</u> Middle <u>Phillips</u> Last <u>Phillips</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 8 - 1883</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <u>Q.A. County Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Phillips</u>				14. MOTHER'S MAIDEN NAME <u>Coursey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-18-6884</u>			
17. INFORMANT <u>Rembert Phillips--Barclay, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 4222 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Cerebral Arteriosclerosis</u> (c) <u>Chronic Myocarditis</u> DUE TO DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smoking</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u> </u>				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>60</u> , to <u>Oct 16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 20</u> , 19 <u>67</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>C.H. Metcalfe</u>				22b. DATE SIGNED <u>10/17/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>C.H. Metcalfe</u>				22d. ADDRESS <u>Sudlersville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Oct. 18</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Sudlersville</u>				23d. LOCATION (City, town or county) (State) <u>Sudlersville, Maryland</u>			
24. FUNERAL DIRECTOR <u>Edgar S. Lane</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
ADDRESS <u>Church Hill, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>OCT 20 1967</u>							

2524

500 05 700

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

14430

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14436

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill		c. LENGTH OF STAY IN lb Most of Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle Elizabeth Last Wells				4. DATE OF DEATH Month Oct Day 11 Year 1967			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1899		9. AGE (In years lost birthday) yrs. 68	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Queen Anne County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Parker				14. MOTHER'S MAIDEN NAME Mary Jane Martin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Edith Riley, Church Hill, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 723.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Intersecting Heart Brains DUE TO 8 years (c) Degenerative Osteoarthritis						INTERVAL BETWEEN ONSET AND DEATH 30 mins 5 years 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John R. Smith, Jr. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John R. Smith, Jr. M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/14/1967		23c. NAME OF CEMETERY OR CREMATORY Salem Cemetery		23d. LOCATION (City or Town) (County) (State) Browns Corner, QA Co. Md/	
24. FUNERAL DIRECTOR Richard H. Allen				25a. REC'D BY REGISTRAR OCT 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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